

5975 Parkway North Blvd., Suite D
Cumming, GA 30040
(p) 404-388-3909
(f) 678-712-1945

316 Maxwell. Rd., Suite 100
Alpharetta, GA 30009
www.focusforwardcc.com
info@focusforwardcc.com

Informed Consent for Walk and Talk Therapy

I hereby give my voluntary and informed consent to participate in Walk and Talk Therapy. I understand that this form outlines the nature and procedures of this therapeutic approach.

Description of Walk and Talk Therapy:

Walk and Talk Therapy involves conducting therapy sessions while walking outdoors. This form of therapy combines the benefits of physical activity and the therapeutic process, providing a unique and potentially beneficial experience. The session may take place in public parks, trails, or other outdoor settings.

Benefits:

- A potentially more relaxed and informal atmosphere compared to traditional therapy settings.
- The integration of nature and movement to support the therapeutic process.
- Opportunity to activate behavioral change and practice coping strategies in a practical manner within the therapeutic environment.

Risks:

- Limited confidentiality: While efforts will be made to choose private and quiet locations, it's essential to be aware that privacy cannot be guaranteed in outdoor settings.
- Physical exertion: Walking may involve physical effort, and participants should inform the therapist of any health concerns that might impact their ability to engage in physical activity.

Limits to Confidentiality:

I understand that the therapist will take reasonable steps to maintain confidentiality during Walk and Talk Therapy sessions. However, due to the nature of the outdoor setting, confidentiality cannot be guaranteed. I acknowledge that others may potentially over-hear our conversations.

Assumption of Responsibility:

I agree to take responsibility for my own physical safety during Walk and Talk Therapy sessions. I will inform the therapist of any health concerns or limitations that may affect my ability to participate in physical activity.

Emergency Procedures:

In the event of an emergency, the therapist will make efforts to ensure the safety and well-being of all parties involved. Emergency contact information will be kept on file.

Alternatives:

I understand that traditional in-office or telehealth therapy is available as an alternative to Walk and Talk Therapy, and I have the right to request a change in the therapeutic approach at any time.

Termination of Services:

Either party may terminate Walk and Talk Therapy sessions at any time. If the therapist determines that Walk and Talk Therapy is no longer suitable or effective for the client, alternative therapeutic arrangements will be discussed.

Consent:

I have read and understood the information provided in this form. I have had the opportunity to ask questions, and any concerns I raised have been addressed to my satisfaction. I voluntarily consent to participate in Walk and Talk Therapy.

Client name (please print)

Date

Client signature

Date

If Applicable:

Parent's or Legal Guardian's name (please print)

Date

Parent's or Legal Guardian's signature

Date